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AMENDED IN ASSEMBLY APRIL 29, 1996
AMENDED IN ASSEMBLY APRIL 22, 1996
AMENDED IN ASSEMBLY MARCH 27, 1996

CALIFORNIA LEGISLATURE—1995–96 REGULAR SESSION

ASSEMBLY BILL

No. 3142

Introduced by Assembly Member Granlund

February 23, 1996

An act to amend Sections 10198.6 ~~and 10700~~, 10700, and 12725 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 3142, as amended, Granlund. Insurance: health coverage.

Existing law limits exclusions for preexisting conditions or late enrollees by a health benefit plan. Under existing law, a health benefit plan is a group or individual policy or contract that provides medical, hospital, and surgical benefits, but does not include accident only, credit, disability income, and certain other forms of coverage.

Existing law regulates health benefit plans offered by small employer carriers. Under existing law, a health benefit plan is a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents,

but does not include accident only, credit, disability income, and certain other forms of coverage.

This bill would also exclude from both definitions of “health benefit plan” set forth above, policies or certificates of specified disease—~~or~~ *and policies or certificates of* hospital confinement indemnity if the carrier offering those policies or certificates files a certificate with the Insurance Commissioner containing specified information.

Existing law establishes the Major Risk Medical Insurance Program, in which persons unable to secure adequate private health coverage may apply for health coverage. To be eligible, a person must have been rejected for coverage by at least one private health plan.

This bill would provide that rejection for policies or certificates of specified disease or policies or certificates of hospital confinement indemnity, as described, shall not be deemed to be rejection for the purposes of determining eligibility for the Major Risk Medical Insurance Program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 10198.6 of the Insurance Code is
2 amended to read:

3 10198.6. For purposes of this article:

4 (a) (1) “Health benefit plan” means any group or
5 individual policy or contract that provides medical,
6 hospital, and surgical benefits.

7 (2) “Health benefit plan” does not include accident
8 only, credit, disability income, coverage of medicare
9 services pursuant to contracts with the United States
10 government, medicare supplement, long-term care
11 insurance, dental, vision, coverage issued as a supplement
12 to liability insurance, insurance arising out of a workers’
13 compensation or similar law, automobile medical
14 payment insurance, or insurance under which benefits
15 are payable with or without regard to fault and that is
16 statutorily required to be contained in any liability
17 insurance policy or equivalent self-insurance.



(3) “Health benefit plan” does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(A) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in subparagraph (B).

(B) The certification required in subparagraph (A) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph (I) are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance, ~~and (II) the disclosure forms as described in Section 10603 contains the following statement prominently on the first page: “This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance,”~~ and (III) are not being offered, marketed, or sold in a manner that would make the purchase of the policies contingent upon the sale of any product sold under Sections 10700 and 10718, or under Section 1357 of the Health and Safety Code.

(ii) A summary description of each policy or certificate described in this paragraph, including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender, or other factors, charged for the policies and certificates in this state.

(C) In the case of a policy or certificate that is described in this paragraph and that is offered for the first time in this state on or after January 1, 1997, the carrier files with the commissioner the information and statement required in subparagraph (B) at least 30 days prior to the date such a policy or certificate is issued or delivered in this state.

1 (4) *As used in paragraph (3), “policies or certificates*
2 *of specified disease” and “policies or certificates of*
3 *hospital confinement indemnity” mean policies or*
4 *certificates of insurance sold to an insured to supplement*
5 *other health insurance coverage as specified in this*
6 *paragraph. An insurer issuing a “policy or certificate of*
7 *specified disease” or a “policy or certificate of hospital*
8 *confinement indemnity” shall require that the person to*
9 *be insured is covered by an individual or group policy or*
10 *contract that arranges or provides medical, hospital, and*
11 *surgical coverage not designed to supplement other*
12 *private or governmental plans.*

13 (b) “Late enrollee” means an eligible employee or
14 dependent who has declined health coverage under a
15 health benefit plan offered through employment or
16 sponsored by an employer at the time of the initial
17 enrollment period provided under the terms of the
18 health benefit plan, and who subsequently requests
19 enrollment in a health benefit plan of that employer;
20 provided that the initial enrollment period shall be a
21 period of at least 30 days. However, an eligible employee
22 or dependent shall not be considered a late enrollee if any
23 of the following is applicable:

24 (1) The individual meets all of the following
25 requirements:

26 (A) The individual was covered under another
27 employer health benefit plan at the time the individual
28 was eligible to enroll.

29 (B) The individual certified, at the time of the initial
30 enrollment that coverage under another employer health
31 benefit plan was the reason for declining enrollment
32 provided that, if the individual was covered under
33 another employer health plan, the individual was given
34 the opportunity to make the certification required by this
35 subdivision and was notified that failure to do so could
36 result in later treatment as a late enrollee.

37 (C) The individual has lost or will lose coverage under
38 another employer health benefit plan as a result of
39 termination of employment of the individual or of a
40 person through whom the individual was covered as a

1 dependent, change in employment status of the
2 individual or of a person through whom the individual
3 was covered as a dependent, termination of the other
4 plan's coverage, cessation of an employer's contribution
5 toward an employee or dependent's coverage, death of a
6 person through whom the individual was covered as a
7 dependent, or divorce.

8 (D) The individual requests enrollment within 30 days
9 after termination of coverage, or cessation of employer
10 contribution toward coverage provided under another
11 employer health benefit plan.

12 (2) The individual is employed by an employer that
13 offers multiple health benefit plans and the individual
14 elects a different plan during an open enrollment period.

15 (3) A court has ordered that coverage be provided for
16 a spouse or minor child under a covered employee's
17 health benefit plan and request for enrollment is made
18 within 30 days after issuance of the court order.

19 (4) The carrier cannot produce a written statement
20 from the employer stating that, prior to declining
21 coverage, the individual or the person through whom the
22 individual was eligible to be covered as a dependent was
23 provided with, and signed acknowledgment of, explicit
24 written notice in bold type specifying that failure to elect
25 coverage during the initial enrollment period permits the
26 carrier to impose, at the time of the individual's later
27 decision to elect coverage, an exclusion from coverage for
28 a period of 12 months as well as a six month preexisting
29 condition exclusion, unless the individual meets the
30 criteria specified in paragraph (1), (2), or (3).

31 (c) "Preexisting condition provision" means a policy
32 provision that excludes coverage for charges or expenses
33 incurred during a specified period following the insured's
34 effective date of coverage, as to a condition for which
35 medical advice, diagnosis, care, or treatment was
36 recommended or received during a specified period
37 immediately preceding the effective date of coverage.

38 (d) "Qualifying prior coverage" means:

39 (1) Any individual or group policy, contract or
40 program, that is written or administered by a disability

1 insurance company, nonprofit hospital service plan,
2 health care service plan, fraternal benefits society,
3 self-insured employer plan, or any other entity, in this
4 state or elsewhere, and that arranges or provides medical,
5 hospital, and surgical coverage not designed to
6 supplement other private or governmental plans. The
7 term includes continuation or conversion coverage but
8 does not include accident only, credit, disability income,
9 medicare supplement, long-term care insurance, dental,
10 vision, coverage issued as a supplement to liability
11 insurance, insurance arising out of a workers'
12 compensation or similar law, automobile medical
13 payment insurance, or insurance under which benefits
14 are payable with or without regard to fault and that is
15 statutorily required to be contained in any liability
16 insurance policy or equivalent self-insurance.

17 (2) The federal medicare program pursuant to Title
18 XVIII of the Social Security Act.

19 (3) The medicaid program pursuant to Title XIX of
20 the Social Security Act.

21 (4) Any other publicly sponsored program, provided
22 in this state or elsewhere, of medical, hospital and surgical
23 care.

24 SEC. 2. Section 10700 of the Insurance Code is
25 amended to read:

26 10700. As used in this chapter:

27 (a) "Agent or broker" means a person or entity
28 licensed under Chapter 5 (commencing with Section
29 1621) of Part 2 of Division 1.

30 (b) "Benefit plan design" means a specific health
31 coverage product issued by a carrier to small employers,
32 to trustees of associations that include small employers, or
33 to individuals if the coverage is offered through
34 employment or sponsored by an employer. It includes
35 services covered and the levels of copayment and
36 deductibles, and it may include the professional providers
37 who are to provide those services and the sites where
38 those services are to be provided. A benefit plan design
39 may also be an integrated system for the financing and
40 delivery of quality health care services which has

1 significant incentives for the covered individuals to use
2 the system.

3 (c) “Board” means the Major Risk Medical Insurance
4 Board.

5 (d) “Carrier” means any disability insurance
6 company, nonprofit hospital service plan, or any other
7 entity that writes, issues, or administers health benefit
8 plans that cover the employees of small employers,
9 regardless of the situs of the contract or master
10 policyholder. For the purposes of Articles 3 (commencing
11 with Section 10719) and 4 (commencing with Section
12 10730), “carrier” also includes health care service plans.

13 (e) “Dependent” means the spouse or child of an
14 eligible employee, subject to applicable terms of the
15 health benefit plan covering the employee, and includes
16 dependents of guaranteed association members if the
17 association elects to include dependents under its health
18 coverage at the same time it determines its membership
19 composition pursuant to subdivision (z).

20 (f) “Eligible employee” means either of the following:

21 (1) Any permanent employee who is actively engaged
22 on a full-time basis in the conduct of the business of the
23 small employer with a normal workweek of at least 30
24 hours, in the small employer’s regular place of business,
25 who has met any statutorily authorized applicable
26 waiting period requirements. The term includes sole
27 proprietors or partners of a partnership, if they are
28 actively engaged on a full-time basis in the small
29 employer’s business, and they are included as employees
30 under a health benefit plan of a small employer, but does
31 not include employees who work on a part-time,
32 temporary, or substitute basis. It includes any eligible
33 employee as defined in this paragraph who obtains
34 coverage through a guaranteed association. Employees of
35 employers purchasing through a guaranteed association
36 shall be deemed to be eligible employees if they would
37 otherwise meet the definition except for the number of
38 persons employed by the employer.

39 (2) Any member of a guaranteed association as
40 defined in subdivision (z).

(g) “Enrollee” means an eligible employee or dependent who receives health coverage through the program from a participating carrier.

(h) “Financially impaired” means, for the purposes of this chapter, a carrier that, on or after the effective date of this chapter, is not insolvent and is either:

(1) Deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(i) “Fund” means the California Small Group Reinsurance Fund.

(j) “Health benefit plan” means a policy or contract written or administered by a carrier that arranges or provides health care benefits for the covered eligible employees of a small employer and their dependents.

(2) “Health benefit plan” does not include accident only, credit, disability income, coverage of medicare services pursuant to contracts with the United States government, medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(3) “Health benefit plan” does not include policies or certificates of specified disease or hospital confinement indemnity provided that the carrier offering those policies or certificates complies with the following:

(A) The carrier files, on or before March 1 of each year, a certification with the commissioner that contains the statement and information described in subparagraph (B).

(B) The certification required in subparagraph (A) shall contain the following:

(i) A statement from the carrier certifying that policies or certificates described in this paragraph (I) are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical

1 expense insurance, health care service plans, or major
 2 medical expense insurance, ~~and (H)~~ *(II) the disclosure*
 3 *forms as described in Section 10603 contains the following*
 4 *statement prominently on the first page: "This is a*
 5 *supplement to health insurance. It is not a substitute for*
 6 *hospital or medical expense insurance, a health*
 7 *maintenance organization (HMO) contract, or major*
 8 *medical expense insurance,"* and *(III)* are not being
 9 offered, marketed, or sold in a manner that would make
 10 the purchase of the policies contingent upon the sale of
 11 any product sold under Sections 10700 and 10718, or
 12 under Section 1357 of the Health and Safety Code.

13 (ii) A summary description of each policy or
 14 certificate described in this paragraph, including the
 15 average annual premium rates, or range of premium
 16 rates in cases where premiums vary by age, gender, or
 17 other factors, charged for the policies and certificates in
 18 this state.

19 (C) In the case of a policy or certificate that is
 20 described in this paragraph and that is offered for the first
 21 time in this state on or after January 1, 1997, the carrier
 22 files with the commissioner the information and
 23 statement required in subparagraph (B) at least 30 days
 24 prior to the date such a policy or certificate is issued or
 25 delivered in this state.

26 (4) *As used in paragraph (3), "policies or certificates*
 27 *of specified disease" and "policies or certificates of*
 28 *hospital confinement indemnity" mean policies or*
 29 *certificates of insurance sold to an insured to supplement*
 30 *other health insurance coverage as specified in this*
 31 *paragraph. An insurer issuing a "policy or certificate of*
 32 *specified disease" or a "policy or certificate of hospital*
 33 *confinement indemnity" shall require that the person to*
 34 *be insured is covered by an individual or group policy or*
 35 *contract that arranges or provides medical, hospital, and*
 36 *surgical coverage not designed to supplement other*
 37 *private or governmental plans.*

38 (k) "In force business" means an existing health
 39 benefit plan issued by the carrier to a small employer.

1 (l) "Late enrollee" means an eligible employee or
2 dependent who has declined health coverage under a
3 health benefit plan offered by a small employer at the
4 time of the initial enrollment period provided under the
5 terms of the health benefit plan, and who subsequently
6 requests enrollment in a health benefit plan of that small
7 employer; provided that the initial enrollment period
8 shall be a period of at least 30 days. It also means any
9 member of an association that is a guaranteed association
10 as well as any other person eligible to purchase through
11 the guaranteed association when that person has failed to
12 purchase coverage during the initial enrollment period
13 provided under the terms of the guaranteed association's
14 health benefit plan and who subsequently requests
15 enrollment in the plan, provided that the initial
16 enrollment period shall be a period of at least 30 days.
17 However, an eligible employee, another person eligible
18 for coverage through a guaranteed association pursuant
19 to subdivision (z), or dependent shall not be considered
20 a late enrollee if: (1) the individual meets all of the
21 following: (A) was covered under another employer
22 health benefit plan at the time the individual was eligible
23 to enroll; (B) certified at the time of the initial
24 enrollment, that coverage under another employer
25 health benefit plan was the reason for declining
26 enrollment provided that, if the individual was covered
27 under another employer health plan, the individual was
28 given the opportunity to make the certification required
29 by this subdivision and was notified that failure to do so
30 could result in later treatment as a late enrollee; (C) has
31 lost or will lose coverage under another employer health
32 benefit plan as a result of termination of employment of
33 the individual or of a person through whom the individual
34 was covered as a dependent, change in employment
35 status of the individual, or of a person through whom the
36 individual was covered as a dependent, the termination
37 of the other plan's coverage, cessation of an employer's
38 contribution toward an employee or dependent's
39 coverage, death of the person through whom the
40 individual was covered as a dependent, or divorce; and



1 (D) requests enrollment within 30 days after termination
2 of coverage or employer contribution toward coverage
3 provided under another employer health benefit plan; or
4 (2) the individual is employed by an employer who offers
5 multiple health benefit plans and the individual elects a
6 different plan during an open enrollment period; or (3)
7 a court has ordered that coverage be provided for a
8 spouse or minor child under a covered employee's health
9 benefit plan; or (4) (A) in the case of an eligible employee
10 as defined in paragraph (1) of subdivision (f), the carrier
11 cannot produce a written statement from the employer
12 stating that the individual or the person through whom
13 an individual was eligible to be covered as a dependent,
14 prior to declining coverage, was provided with, and
15 signed acknowledgment of, an explicit written notice in
16 bold type specifying that failure to elect coverage during
17 the initial enrollment period permits the carrier to
18 impose, at the time of the individual's later decision to
19 elect coverage, an exclusion from coverage for a period
20 of 12 months as well as a six-month preexisting condition
21 exclusion unless the individual meets the criteria
22 specified in paragraph (1), (2), or (3); (B) in the case of
23 an eligible employee who is a guaranteed association
24 member, the plan cannot produce a written statement
25 from the guaranteed association stating that the
26 association sent a written notice in bold type to all
27 association members at their last known address prior to
28 the initial enrollment period informing members that
29 failure to elect coverage during the initial enrollment
30 period permits the plan to impose, at the time of the
31 member's later decision to elect coverage, an exclusion
32 from coverage for a period of 12 months as well as a
33 six-month preexisting condition exclusion unless the
34 member can demonstrate that he or she meets the
35 requirements of subparagraphs (A), (C), and (D) of
36 paragraph (1) or paragraph (2) or (3); or (C) in the case
37 of an employer or person who is not a member of an
38 association, was eligible to purchase coverage through a
39 guaranteed association, and did not do so, and would not
40 be eligible to purchase guaranteed coverage unless

1 purchased through a guaranteed association, the
2 employer or person can demonstrate that he or she meets
3 the requirements of subparagraphs (A), (C), and (D) of
4 paragraph (1), or paragraph (2) or (3), or that he or she
5 recently had a change in status that would make him or
6 her eligible and that application for coverage was made
7 within 30 days of the change.

8 (m) “New business” means a health benefit plan
9 issued to a small employer that is not the carrier’s in force
10 business.

11 (n) “Participating carrier” means a carrier that has
12 entered into a contract with the program to provide
13 health benefits coverage under this part.

14 (o) “Plan of operation” means the plan of operation of
15 the fund, including articles, bylaws and operating rules
16 adopted by the fund pursuant to Article 3 (commencing
17 with Section 10719).

18 (p) “Program” means the Voluntary Alliance Uniting
19 Employers Purchasing Program.

20 (q) “Preexisting condition provision” means a policy
21 provision that excludes coverage for charges or expenses
22 incurred during a specified period following the insured’s
23 effective date of coverage, as to a condition for which
24 medical advice, diagnosis, care, or treatment was
25 recommended or received during a specified period
26 immediately preceding the effective date of coverage.

27 (r) “Qualifying prior coverage” means:

28 (1) Any individual or group policy, contract, or
29 program, that is written or administered by a disability
30 insurer, nonprofit hospital service plan, health care
31 service plan, fraternal benefits society, self-insured
32 employer plan, or any other entity, in this state or
33 elsewhere, and that arranges or provides medical,
34 hospital, and surgical coverage not designed to
35 supplement other private or governmental plans. The
36 term includes continuation or conversion coverage but
37 does not include accident only, credit, disability income,
38 medicare supplement, long-term care, dental, vision,
39 coverage issued as a supplement to liability insurance,
40 insurance arising out of a workers’ compensation or

1 similar law, automobile medical payment insurance, or
2 insurance under which benefits are payable with or
3 without regard to fault and that is statutorily required to
4 be contained in any liability insurance policy or
5 equivalent self-insurance.

6 (2) The federal medicare program pursuant to Title
7 XVIII of the Social Security Act.

8 (3) The medicaid program pursuant to Title XIX of
9 the Social Security Act.

10 (4) Any other publicly sponsored program, provided
11 in this state or elsewhere, of medical, hospital, and
12 surgical care.

13 (s) "Rating period" means the period for which
14 premium rates established by a carrier are in effect and
15 shall be no less than six months.

16 (t) "Risk adjusted employee risk rate" means the rate
17 determined for an eligible employee of a small employer
18 in a particular risk category after applying the risk
19 adjustment factor.

20 (u) "Risk adjustment factor" means the percent
21 adjustment to be applied equally to each standard
22 employee risk rate for a particular small employer, based
23 upon any expected deviations from standard claims. This
24 factor may not be more than 120 percent or less than 80
25 percent until July 1, 1996. Effective July 1, 1996, this factor
26 may not be more than 110 percent or less than 90 percent.

27 (v) "Risk category" means the following
28 characteristics of an eligible employee: age, geographic
29 region, and family size of the employee, plus the benefit
30 plan design selected by the small employer.

31 (1) No more than the following age categories may be
32 used in determining premium rates:

- 33 Under 30
- 34 30-39
- 35 40-49
- 36 50-54
- 37 55-59
- 38 60-64
- 39 65 and over

1 However, for the 65 and over age category, separate
2 premium rates may be specified depending upon
3 whether coverage under the health benefit plan will be
4 primary or secondary to benefits provided by the federal
5 medicare program pursuant to Title XVIII of the federal
6 Social Security Act.

7 (2) Small employer carriers shall base rates to small
8 employers using no more than the following family size
9 categories:

10 (A) Single.

11 (B) Married couple.

12 (C) One adult and child or children.

13 (D) Married couple and child or children.

14 (3) (A) In determining rates for small employers, a
15 carrier that operates statewide shall use no more than
16 nine geographic regions in the state, have no region
17 smaller than an area in which the first three digits of all
18 its ZIP Codes are in common within a county and shall
19 divide no county into more than two regions. Carriers
20 shall be deemed to be operating statewide if their
21 coverage area includes 90 percent or more of the state's
22 population. Geographic regions established pursuant to
23 this section shall, as a group, cover the entire state, and
24 the area encompassed in a geographic region shall be
25 separate and distinct from areas encompassed in other
26 geographic regions. Geographic regions may be
27 noncontiguous.

28 (B) In determining rates for small employers, a carrier
29 that does not operate statewide shall use no more than the
30 number of geographic regions in the state than is
31 determined by the following formula: the population, as
32 determined in the last federal census, of all counties
33 which are included in their entirety in a carrier's service
34 area divided by the total population of the state, as
35 determined in the last federal census, multiplied by nine.
36 The resulting number shall be rounded to the nearest
37 whole integer. No region may be smaller than an area in
38 which the first three digits of all its ZIP Codes are in
39 common within a county and no county may be divided
40 into more than two regions. The area encompassed in a

1 geographic region shall be separate and distinct from
2 areas encompassed in other geographic regions.
3 Geographic regions may be noncontiguous. No carrier
4 shall have less than one geographic area.

5 (w) "Small employer" means either of the following:

6 (1) Any person, proprietary or nonprofit firm,
7 corporation, partnership, public agency, or association
8 that is actively engaged in business or service that, on at
9 least 50 percent of its working days during the preceding
10 calendar quarter, employed at least three, but not more
11 than 50, eligible employees, the majority of whom were
12 employed within this state, that was not formed primarily
13 for purposes of buying health insurance and in which a
14 bona fide employer-employee relationship exists.
15 However, for purposes of subdivisions (b) and (h) of
16 Section 10705, the definition shall include employers with
17 at least five eligible employees until July 1, 1994, four
18 eligible employees until July 1, 1995, and three eligible
19 employees thereafter. In determining the number of
20 eligible employees, companies that are affiliated
21 companies, and that are eligible to file a combined
22 income tax return for purposes of state taxation shall be
23 considered one employer. Subsequent to the issuance of
24 a health benefit plan to a small employer pursuant to this
25 chapter, and for the purpose of determining eligibility,
26 the size of a small employer shall be determined annually.
27 Except as otherwise specifically provided, provisions of
28 this chapter that apply to a small employer shall continue
29 to apply until the health benefit plan anniversary
30 following the date the employer no longer meets the
31 requirements of this definition. It includes any small
32 employer as defined in this paragraph who purchases
33 coverage through a guaranteed association, and any
34 employer purchasing coverage for employees through a
35 guaranteed association.

36 (2) Any guaranteed association, as defined in
37 subdivision (y), that purchases health coverage for
38 members of the association.

1 (x) “Standard employee risk rate” means the rate
2 applicable to an eligible employee in a particular risk
3 category in a small employer group.

4 (y) “Guaranteed association” means a nonprofit
5 organization comprised of a group of individuals or
6 employers who associate based solely on participation in
7 a specified profession or industry, accepting for
8 membership any individual or employer meeting its
9 membership criteria which (1) includes one or more
10 small employers as defined in paragraph (1) of
11 subdivision (w), (2) does not condition membership
12 directly or indirectly on the health or claims history of any
13 person, (3) uses membership dues solely for and in
14 consideration of the membership and membership
15 benefits, except that the amount of the dues shall not
16 depend on whether the member applies for or purchases
17 insurance offered by the association, (4) is organized and
18 maintained in good faith for purposes unrelated to
19 insurance, (5) has been in active existence on January 1,
20 1992, and for at least five years prior to that date, (6) has
21 been offering health insurance to its members for at least
22 five years prior to January 1, 1992, (7) has a constitution
23 and bylaws, or other analogous governing documents that
24 provide for election of the governing board of the
25 association by its members, (8) offers any benefit plan
26 design that is purchased to all individual members and
27 employer members in this state, (9) includes any
28 member choosing to enroll in the benefit plan design
29 offered to the association provided that the member has
30 agreed to make the required premium payments, and
31 (10) covers at least 1,000 persons with the carrier with
32 which it contracts. The requirement of 1,000 persons may
33 be met if component chapters of a statewide association
34 contracting separately with the same carrier cover at
35 least 1,000 persons in the aggregate.

36 This subdivision applies regardless of whether a master
37 policy by an admitted insurer is delivered directly to the
38 association or a trust formed for or sponsored by an
39 association to administer benefits for association
40 members.

1 For purposes of this subdivision, an association formed
2 by a merger of two or more associations after January 1,
3 1992, and otherwise meeting the criteria of this
4 subdivision shall be deemed to have been in active
5 existence on January 1, 1992, if its predecessor
6 organizations had been in active existence on January 1,
7 1992, and for at least five years prior to that date and
8 otherwise met the criteria of this subdivision.

9 (z) "Members of a guaranteed association" means any
10 individual or employer meeting the association's
11 membership criteria if that person is a member of the
12 association and chooses to purchase health coverage
13 through the association. At the association's discretion, it
14 may also include employees of association members,
15 association staff, retired members, retired employees of
16 members, and surviving spouses and dependents of
17 deceased members. However, if an association chooses to
18 include those persons as members of the guaranteed
19 association, the association must so elect in advance of
20 purchasing coverage from a plan. Health plans may
21 require an association to adhere to the membership
22 composition it selects for up to 12 months.

23 *SEC. 3. Section 12725 of the Insurance Code is*
24 *amended to read:*

25 12725. Each resident of the state meeting the
26 eligibility criteria of this section and who is unable to
27 secure adequate private health coverage is eligible to
28 apply for major risk medical coverage through the
29 program. To be eligible for enrollment in the program an
30 applicant shall have been rejected for health care
31 coverage by at least one private health plan. An applicant
32 shall be deemed to have been rejected if the only private
33 health coverage which the applicant could secure would
34 (1) impose substantial waivers which the program
35 determines would leave a subscriber without adequate
36 coverage for medically necessary services, or (2) would
37 afford such limited coverage, as the program determines
38 would leave the subscriber without adequate coverage
39 for medically necessary services, or (3) would afford
40 coverage only at an excessive price, which the board

1 determines is significantly above standard average
2 individual coverage rates. *Rejection for policies or*
3 *certificates of specified disease or policies or certificates*
4 *of hospital confinement indemnity, as described in*
5 *paragraph (3) of subdivision (a) of Section 10198.6, shall*
6 *not be deemed to be rejection for the purposes of*
7 *eligibility for enrollment.* The board may permit
8 dependents of eligible subscribers to enroll in major risk
9 medical coverage through the program if the board
10 determines the enrollment can be carried out in an
11 actuarially and administratively sound manner.

